MEDI-CAL UPDATE Part 2
Billing and Policy
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Contents

Spinal Osteogenic Bone Growth Stimulator Benefits Added

Effective for dates of service on or after September 1, 2006, noninvasive electrical osteogenesis stimulator for spinal application HCPCS code E0748 will be a Medi-Cal benefit, subject to prior authorization. Pursuant to *Welfare and Institutions Code*, Section 14105.48, the purchase reimbursement rate for code E0748 has been established at $3,030.73.

The coverage policies for osteogenic stimulators, E0747 (electrical non-spinal), E0748 (electrical spinal), and E0760 (ultrasound) have been updated as follows:

- A dated order for the osteogenesis stimulator and related supply items, signed by the treating physician, must be kept on file by the supplier of the equipment.
- All claims for an osteogenesis stimulator and related supplies must include an ICD-9 code that describes the condition requiring the device. For nonunion fractures, the claim must include both the ICD-9 code 733.82 (nonunion of fracture) and the specific ICD-9 code for the fracture site.

Non-Spinal, Electrical Osteogenesis Stimulator
Non-spinal electrical osteogenesis stimulator devices are billed with HCPCS code E0747 and are covered for nonunion fractures only if the following criteria are met:

- Nonunion of a long bone fracture, defined as radiographic evidence that fracture healing has ceased.
- Six months or more have passed since the fracture.
- Bone X-rays over the last three months show no sign of continued healing.
- Six months or more have passed since the alternative treatment was initiated.
- The fracture gap is one centimeter or less.
- The patient can be adequately immobilized and is able to comply with non-weight bearing.
- For infantile (congenital) pseudoarthroses (ICD-9 code 755.8).
- There is evidence of skeletal maturity or the patient is 20 years of age or older.

Note: Nonunion of the long bone must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and including a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of films.

A non-spinal electrical osteogenesis stimulator will be denied as not medically necessary if none of the above criteria are met.

Please see **Bone Growth**, *page 2*

Spinal, Electrical Osteogenesis Stimulator
Spinal electrical osteogenesis stimulator devices are billed with HCPCS code E0748 and are covered only if any of the following applies:

- Failed spinal fusion (pseudoarthrosis-ICD-9 code V45.4, joint following fusion) and a minimum of nine months have elapsed since the last surgery, or
- Following a multi-level spinal fusion surgery, involving three or more vertebrae (for example, L3-5, L4-S1, etc.), or
- Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site, or
- The patient has one or more risk factors for high risk of spinal fusion failure such as: smoking, obesity (BMI > 35), diabetes, renal disease, alcoholism, grade II or worse Spondylolisthesis, or other metabolic disease where bone healing is poor.

Note: The device should be applied within 30 days as an adjunct to spinal fusion surgery. The patient should use the device for at least two hours per day and the treatment period continued for nine months (270 consecutive days). The device is programmed to cease operation at the end of 270 days.

Non-Invasive, Low Intensity Ultrasound Treatment
Non-invasive, low intensity ultrasound osteogenesis devices are billed with HCPCS code E0760 and are reimbursable at a "per treatment" rate only if the following criteria are met:

- Nonunion of a fracture other than the skull or vertebrae in a skeletally mature person, documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days each, including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and
- The fracture is not tumor-related.
- Fresh (< 7days), closed or grade I open, tibial diaphyseal fractures; or
- Fresh (< 7days), closed fractures of the distal radius (Colles fracture).

Note: An ultrasonic osteogenesis stimulator will be denied as not medically necessary if the criteria above are not met. An ultrasonic osteogenesis stimulator may not be used concurrently with other noninvasive stimulators.

Reimbursement
The purchase-only reimbursement is all-inclusive of the following:

- All accessories necessary to use the unit (for example, electrodes, wires, gel, cables, etc.)
- Patient education on the proper use and care of the equipment
- Routine servicing and all necessary repairs or replacement to make the unit functional

This information is reflected on manual replacement pages dura cd 24 (Part 2) and tax 6 and 7 (Part 2).

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. The affected codes are listed below. Only those codes representing current or future Medi-Cal benefits are included. Please refer to the 2006 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update.*

Please see **Updates**, *page 3*

HCPCS Level II Code Additions

Durable Medical Equipment and Supplies
A4604, A9281, E0170, E0171, E0641, E0642, E0705, E0911, E0912, E1392, E2207 – E2215, E2218 – E2226, E2371, E2372, K0734 – K0737

Orthotic Procedures and Devices
L0491, L0492, L0621 – L0640, L0859, L2034, L2387, L3671 – L3673, L3702, L3763 – L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975 – L3978

Prosthetic Procedures and Appliances
A6513, A6542, A6544, L5703, L5858, L5971, L6621, L6677, L6883 – L6885, L7400 – L7405

HCPCS Level II Codes with Description Changes

Durable Medical Equipment and Supplies
A4632, A6550, A7032, A7033, A8033, E0240, E0463, E0464, E0637, E0638, E0935, E0971, E1038, E1039, K0669

Orthotic Procedures and Devices
L1832, L1843 – L1846, L2036 – L2038, L2405, L3215 – L3217, L3219, L3221, L3222, L3230, L3906, L3923, L8010

HCPCS Level II Code Deletions

Durable Medical Equipment
A6551, E0972, E1019, E1021, E1025 – E1027, K0064, K0066 – K0068, K0074 – K0076, K0078, K0102, K0104, K0106, K0452

Orthotic Procedures and Devices
K0619, K0630 – K0649, L0860, L1750, L2039, L3963

Prosthetic Procedures and Appliances
L8210, L8230

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71	238.72	238.73	238.74
238.75	238.76	238.79	277.30	277.31	277.39	284.01
284.09	284.1	284.2	288.00	288.01	288.02	288.03
288.04	288.09	288.4	288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64	288.65	288.69	289.53
289.83	323.01	323.02	323.41	323.42	323.51	323.52
323.61	323.62	323.63	323.71	323.72	323.81	323.82
331.83	333.71	333.72	333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19	338.21	338.22	338.28
338.29	338.3	338.4	341.20	341.21	341.22	377.43
379.60	379.61	379.62	379.63	389.15	389.16	429.83
478.11	478.19	518.7	519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11	523.30	523.31	523.32
523.33	523.40	523.41	523.42	525.60	525.61	525.62

Please see **Diagnosis**, *page 4*

Diagnosis *(continued)*

Additions (continued)

525.63	525.64	525.65	525.66	525.67	525.69	526.61
526.62	526.63	526.69	528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *	608.23 *	608.24 *	616.81 **
616.89 **	618.84 **	629.29 **	629.81 ** +	629.89 **	649.00 ** +	649.01 ** +
649.02 ** +	649.03 ** +	649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +	649.13 ** +
649.14 ** +	649.20 ** +	649.21 ** +	649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +	649.40 ** +	649.41 ** +	649.42 ** +
649.43 ** +	649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +	649.60 ** +	649.61 ** +
649.62 ** +	649.63 ** +	649.64 ** +	729.71	729.72	729.73	729.79
731.3	768.70 #	770.87 #	770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91	784.99	788.64	788.65
793.91	793.99	795.06 **	795.81	795.82	795.89	958.90
958.91	958.92	958.93	958.99	995.20	995.21	995.22
995.23	995.27	995.29	V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31	V58.32	V72.11	V72.19
V82.71	V82.79	V85.51	V85.52	V85.53	V85.54	V86.0 ** +
V86.1 ** +						

Restrictions

* Restricted to males only
** Restricted to females only
\# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Manual replacement pages reflecting these ICD-9 code updates will be included in a future *Medi-Cal Update.*

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: dura cd 23/24
medi non hcp 1/2 *
tax 5 thru 8

* Pages updated due to ongoing provider manual revisions.